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ON REHEARING

UNPUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 06-2022

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,

Plaintiff - Appellant,

versus

DIXIE NATIONAL LIFE INSURANCE COMPANY; NATIONAL FOUNDATION LIFE INSURANCE COMPANY,

Defendants - Appellees,

and

PALMETTO MARKETING ASSOCIATES, INCORPORATED;
PATTI JENKINS,

Defendants.

SOUTH CAROLINA DEPARTMENT OF INSURANCE;
AMERICA'S HEALTH INSURANCE PLANS, INCORPORATED,

Amici Supporting Appellees.

No. 06-2054

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,
Plaintiff - Appellee,

versus

NATIONAL FOUNDATION LIFE INSURANCE COMPANY,
Defendant - Appellant,

DIXIE NATIONAL LIFE INSURANCE COMPANY,
Defendant - Appellee,

and

PALMETTO MARKETING ASSOCIATES, INCORPORATED;
PATTI JENKINS,
Defendants.

SOUTH CAROLINA DEPARTMENT OF INSURANCE;
AMERICA'S HEALTH INSURANCE PLANS, INCORPORATED,
Amici Supporting Appellant.

Appeals from the United States District Court for the District of South Carolina, at Columbia. Joseph F. Anderson, Jr., Chief District Judge. (3:03-cv-

03239-JFA)

Argued: May 23, 2007 Decided: October 5, 2007
Decided on Rehearing: November 29, 2007

Before MICHAEL and TRAXLER, Circuit Judges, and WIDENER,[1] Senior Circuit Judge.

Vacated in part, affirmed in part, dismissed in part, and remanded by unpublished per curiam opinion.

PER CURIAM:

Plaintiff Martha Ward sued National Foundation Life Insurance Company (National) and Dixie National Life Insurance Company (Dixie), asserting that National refused to pay the full amount of benefits owed under supplemental cancer insurance policies that were issued by Dixie and later assigned to National. The district court certified a statewide (South Carolina) plaintiff class rather than the multistate class Ward sought to represent, and the court later granted summary judgment in favor of National on the breach of contract claims. Ward appealed and National cross-appealed. In a prior opinion, we concluded that although the district

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[1] Judge Widener heard oral argument in this case but died prior to the time the decision was filed. The decision is filed by a quorum of the panel. 28 U.S.C. § 46(d).

court properly limited the plaintiff class to South Carolina residents, the court improperly granted summary judgment on the breach of contract claims, and we remanded for further proceedings on those claims. We dismissed National's cross-appeal without prejudice. *See Ward v. Dixie Nat'l Life Ins. Co.*, 2007 WL 2914954 (4th Cir. Oct. 5, 2007).

Ward filed a petition for rehearing, and National, supported by various amici, filed a petition for rehearing and rehearing *en banc*. We granted Ward's petition for panel rehearing and denied National's petition for rehearing, thus vacating our prior opinion.[2] *See* Fourth Circuit I.O.P. 40.2. Dispensing with further briefing and argument, we now vacate the district court's decision granting summary judgment in favor of National, and we remand with instructions for the district court to instead enter judgment in favor of Ward on the breach of contract claims. In light of our remand, we conclude that it would be premature for us to consider the class certification issue. We therefore dismiss without prejudice National's cross-appeal.

I.

In August 1990 Ward purchased a cancer treatment benefit policy from Dixie covering both herself and her husband. Ward's policy is a type of supplemental insurance under which direct payments are made to the policyholder when an insured patient undergoes covered cancer

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[2] Because no member of the court called for a vote on National's petition for rehearing en banc, the petition was denied. *See* Fourth Circuit Local Rule 35(b).

treatments. Benefits under this kind of policy are paid regardless of whether the patient has other insurance sufficient to cover all medical expenses. When the patient has other insurance covering cancer treatments, the policyholder is able to retain the money received as a result of the supplemental coverage.

Benefits under Ward's policy vary as to the procedure performed. In some sections the policy provides clear caps as to the maximum benefit to be paid. For example, the policy provides a "Schedule of Operations" listing the maximum amount to be paid — ranging from $150 for skin excisions to $3000 for removal of an intracardiac tumor — for a variety of operations. In many other sections of the policy no dollar amounts are provided, and benefits are calculated in relation to the "actual charges" for the covered procedures. Section (F) of the policy, titled "X-ray Therapy, Radium Therapy, Radiation Therapy, and Chemotherapy Benefit," provides an example of this language:

> We will pay the actual charges for teleradiotherapy, using either natural or artificially propagated radiation, when used for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual charges made for plaques or molds or the administration internally, interstitially, or intracavitarially of radium or radioisotopes in sealed sources for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual

> charges for cancericidal chemical substances and the administration thereof for the purpose of the modification or destruction of tissue invaded by cancer.

J.A. 221. Although the phrase is used repeatedly throughout the policy, no definition for "actual charges" is provided.

Dixie assigned Ward's policy to National in 1994. In 2001 Ward began filing claims under the policy after her husband, James Ward (James), was diagnosed with prostate cancer and started receiving treatment. Shortly thereafter, a dispute between Ward and National arose over how benefits paid in the amount of the "actual charges" are calculated.

For a number of years after the assignment, National appears to have calculated benefits in the same manner that Dixie had previously done. Specifically, when the benefit owed was based on the "actual charges," Dixie paid the benefit based on the amounts billed to patients by their medical providers. Dixie paid such amounts even though providers often have agreements with certain insurers to accept as payment-in-full an amount less than that reflected on the patient's bill. In this case, for example, James's primary health insurance is provided through a plan administered by Blue Cross and Blue Shield of South Carolina (BCBS). Regardless of the amounts billed to James, his medical providers have an agreement with BCBS that requires them to accept a discounted amount as payment-in-full for services rendered to BCBS insureds. This agreement prohibits providers from

attempting to collect an amount in excess of the pre-negotiated, discounted fee from BCBS insureds such as James.

Toward the end of the year in 2001, National changed its benefit payment practice. When Ward submitted claims for James's treatments in 2002, she was told that she would have to submit an explanation of benefits (EOB) statement. By viewing the EOB, National would be able to determine what the pre-negotiated discount rate was for James's treatments and calculate benefits in light of this reduced amount. Ward refused to provide National with the EOB statements because she contended that under the terms of her policy, the "actual charge" was reflected in the nondiscounted bill that she received rather than in the EOB.

On March 7, 2003, after Ward was unable to resolve the dispute, she filed an action in the Court of Common Pleas for Richland County, South Carolina, against both Dixie and National. The defendants removed the action to federal court on October 10, 2003. On September 15, 2004, Ward moved to certify a plaintiff class consisting of

> all persons insured under cancer policies from Defendant Dixie National Life Insurance Company where Dixie promised to pay to the insured the "actual charges" incurred for certain medical services, but instead paid not the actual charges but rather the (lesser) amount that the insured's primary health insurer negotiated with the healthcare provider to pay for the medical procedure[.]

S.A. 7. On May 5, 2005, the district court certified a class of South Carolina residents. The court limited the class to South Carolina residents based on its understanding of South Carolina's door-closing statute, S.C. Code Ann. § 15-5-150. Ward, with permission of the court, filed a third amended complaint on September 27, 2005, asserting claims for (1) breach of contract against both Dixie and National; (2) bad faith refusal to pay against National; and (3) breach of contract accompanied by a fraudulent Act against National. Ward later abandoned the bad faith claim. Cross-motions for summary judgment followed. In addition, National filed a motion, joined by Dixie, to decertify the statewide class.

On May 10, 2006, the district court granted National's motion for summary judgment while denying Ward's. The court concluded that under South Carolina contract law, the phrase "actual charges" is not ambiguous and must be read to mean "the charges for which the patient is liable when medical services are rendered, not the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. Because Ward did not prevail on her breach of contract claims, the joint motion to decertify the class and Dixie's motion for summary judgment were denied as moot.

Ward appeals both the grant of summary judgment to National as well as the district court's decision to limit class membership to South Carolina residents. National has filed a cross-appeal contesting the district court's decision to certify even a statewide class.

II.

We begin with Ward's argument that the district court erred in concluding that, as used in her policy, the unambiguous meaning of the phrase "actual charges" is the discounted amount that medical providers have agreed to accept as full payment pursuant to a third-party agreement with another insurer. Under South Carolina law when a term has a "plain, ordinary, and popular meaning," courts must interpret the term to give effect to that ordinary usage. *Century Indem. Co. v. Golden Hills Builders, Inc.*, 561 S.E.2d 355, 358 (S.C. 2002). When a term has a plain meaning and that meaning is "clear and unambiguous, the language [of the contract] alone determines the contract's force and effect." *Schulmeyer v. State Farm Fire & Cas. Co.*, 579 S.E.2d 132, 134 (S.C. 2003). Of course not all terms are susceptible to plain and ordinary definition because of the simple fact that they are not popularly used. As a result, a contract term is ambiguous when it lacks a plain definition and is "capable of more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business." *Hansen v. United Servs. Auto. Ass'n*, 565 S.E.2d 114, 117-18 (S.C. 2002).

In the district court's endeavor to discern the plain meaning of "actual charges" as used in Ward's policy, it reasoned that the word "actual" should be given a separate meaning from the word "charges." Because the district court understood the word

"actual" to mean something that is real or true, it concluded that "actual charges" means the amounts for which the patient is truly liable as opposed to "the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. We disagree both with the district court's interpretive approach as well as the conclusion that it reached. The definition settled on by the district court is not the only one possible when the language of the policy is considered in light of its context. As we explain below, the meaning of the phrase "actual charges" as used in Ward's policy is ambiguous.

First, even under the district court's approach — defining each word separately and then putting those definitions together — another meaning can reasonably be found. The words "actual charges" could also be understood to mean the amount shown on the bill sent to the patient regardless of whether this amount is the same as the amount actually owed. Viewed from within the four corners of the policy, the phrase is ambiguous as there is nothing to indicate whether "actual charges" is best understood to mean the amount actually billed or the amount actually owed. *See Conner v. Am. Pub. Life Ins. Co.*, 448 F. Supp.2d 762, 766 (N.D. Miss. 2006) (finding "inherent ambiguity in the undefined term 'actual charges'"); *Metzger v. Am. Fid. Assur. Co.*, No. CIV-05-1387-M, 2006 U.S. Dist. LEXIS 70061, at *13 (W.D. Okla. Sept. 26, 2006) (same).

Second, we disagree with the assertion that the district court was correct "in considering ordinary dictionary definitions" of both "actual" and "charges." Appellees' Br. at 21. We conclude that a person "who is cognizant of the customs, practices, usages and

terminology as generally understood" in the health insurance industry would regard "actual charges" as a term of art rather than two words to be separately defined. *Hansen*, 565 S.E.2d at 117. The words are used throughout the insurance policy together as a phrase — a phrase that neither appears in a standard dictionary nor has an ordinary, popular usage. Contrary to the defendants' contention, South Carolina's principles of contract interpretation in no way prohibit courts from reading a phrase as a term of art if that is how it would be regarded by an objective observer well-versed in medical insurance terminology. *See Frazier v. Badger*, 603 S.E.2d 587, 591 (S.C. 2004).

Third, even when viewed as a term of art, the phrase remains ambiguous. Prior to filing this lawsuit, Ward wrote to the South Carolina Department of Insurance and asked to be provided with a legal definition of "actual charge." A representative of the Department wrote back explaining that "[t]he term 'actual charge' in industry-wide standards is the amount that you are *legally obligated to pay for a specific service*." J.A. 611 (emphasis in original). In contrast to the view taken by the Department of Insurance, numerous health care dictionaries define "actual charge" as the amount billed. *See, e.g., Mosby's Medical, Nursing, and Allied Health Dictionary* 26 (4th ed. 1994) ("actual charge, the amount actually charged or billed by a medical practitioner for a service. The actual charge may not be the same as that paid for the service by an insurance plan."); Lee Hyde, *The McGraw-Hill Essential Dictionary of Health Care* 133 (1988) ("actual charge. the amount a physician

or other practitioner actually *bills* a patient or his insurance for a medical *service* or *procedure*.") (emphasis in original). Because the policy itself does not indicate which definition was intended by the parties, we conclude that its meaning is ambiguous.[3]

We must now determine what remedy flows from our conclusion that the insurance policy is ambiguous. In a typical contract dispute, the meaning of an ambiguous contract is a question of fact to be resolved by the jury. *See, e.g., Café Assocs., Ltd. v. Gerngross*, 406 S.E.2d 162, 164 (S.C. 1991) ("As a general rule, written contracts are to be construed by the Court; but where a contract is ambiguous or capable of more than one construction, the question of what the parties intended becomes one of fact, and the question should be submitted to the jury."). Although statements of that general rule appear in cases involving insurance disputes, *see Waters v. S. Farm Bureau Life Ins. Co.*, 617 S.E.2d 385, 388 (S.C. Ct. App. 2005), only *latent* ambiguities in an insurance policy are resolved by a jury; *patent*

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[3] National and its supporting amici contend that, absent compelling reasons, we must defer to the Department of Insurance's interpretation of "actual charges." We disagree. Although an agency's interpretation of a statute it is charged with enforcing is entitled to deference, *see Dunton v. S.C. Bd. of Examiners in Optometry*, 353 S.E.2d 132, 133 (S.C. 1987), the Department of Insurance has no statutory mandate to pronounce the meaning of a term in an individual insurance policy. We are of course interested in the Department's position, but South Carolina law does not in this case require us to defer to the Department's view of the matter.

ambiguities must be resolved in favor of the insured. *See Cogdill v. Equity Life & Annuity Co.*, 203 S.E.2d 674, 677 (S.C. 1974); *Hann v. Carolina Cas. Ins. Co.*, 167 S.E.2d 420, 423 (S.C. 1969). Accordingly, if the ambiguity in this case is patent, the district court should have granted summary judgment in favor of Ward on the breach of contract claims. If the ambiguity is latent, the meaning of the policy must be determined by a jury on remand.

A patent ambiguity is one where the uncertainty as to meaning "arises upon the words of the will, deed, or other instrument as looked at in themselves, and before any attempt is made to apply them to the object which they describe." *Hann*, 167 S.E.2d at 422 (quoting *Jennings v. Talbert*, 58 S.E. 420, 421 (S.C. 1907)); *cf. Stone Container Corp. v. Hartford Steam Boiler Inspection & Ins. Co.*, 165 F.3d 1157, 1162 (7th Cir. 1999) ("A patent ambiguity in a contract is one that is apparent from just reading the contract."). With a latent ambiguity, "the uncertainty arises, not upon the words of the will, deed, or other instrument as looked at in themselves, but upon those words when applied to the object or subject which they describe." *Hann*, 167 S.E.2d at 422. A latent ambiguity thus "does not appear on the face of the words used, nor is its existence known until those words are brought into contact with collateral facts." *Hastings v. Union Fire Ins. Co.*, 125 S.E. 923, 924 (S.C. 1924) (internal quotation marks omitted); *cf. Stone Container Corp.*, 165 F.3d at 1162 ("A latent ambiguity arises when, although the contract is clear 'on its face,' anyone knowing the background would know that it didn't mean what it seems to mean.").

We believe that the phrase "actual charges" is patently ambiguous. The phrase is susceptible of more than one reasonable interpretation, and the uncertainty of meaning arises thus from the phrase itself, not from the application of the phrase to collateral facts. *See Cogdill*, 203 S.E.2d at 677 (concluding that "lame back" as used in a policy provision limiting disability benefits could plausibly be construed in more than one way and that the phrase was patently ambiguous); *Hastings*, 125 S.E. at 924 (finding latent ambiguity in fire insurance policy that covered two barns because the insured's property included two traditional barns and an abandoned tenant house used by the insured as a barn).

Because the ambiguity is patent, construction of the policy is for the court rather than a jury. *See Cogdill*, 203 S.E.2d at 677; *Hann*, 167 S.E.2d at 423. South Carolina law very clearly requires us to resolve the ambiguity in favor of the insured. *See Helena Chem. Co. v. Allianz Underwriters Ins. Co.*, 594 S.E.2d 455, 459 (S.C. 2004) ("Where the words of an insurance policy are capable of two reasonable interpretations, the construction most favorable to the insured should be adopted."); *Hann*, 167 S.E.2d at 423 ("It is settled beyond cavil in this jurisdiction that the terms of an insurance policy should be construed most liberally in favor of the insured, and that in case of conflict or ambiguity, a construction will not be adopted that defeats recovery if the policy is reasonably susceptible of a meaning that will permit recovery. We uniformly give the insured the benefit of any doubt in the construction of the terms used in an insurance policy."). Accordingly, we

vacate the district court's grant of summary judgment to National and remand with instructions that the district court enter summary judgment in favor of Ward on her breach of contract claims.

III.

A.

We now turn to the question of whether the district court properly limited the class of plaintiffs to those who, like Ward, are residents of South Carolina. In her motion for class certification, Ward made clear that she sought to represent persons residing throughout the southern United States who had bought policies from Dixie that were later assigned to National. Because the proposed class included non-residents of South Carolina, the district court requested briefing from the parties on the effect of South Carolina's door closing statute, S.C. Code Ann. § 15-5-150, on the potential out-of-state class members. That statute provides:

> An action against a corporation created by or under the laws of any other state government or country may be brought in the circuit court:
>
> (1) By any resident of this State for any cause of action; or
>
> (2) By a plaintiff not a resident of this State when the cause of action shall have arisen or the subject of the action shall be situated within this state.

S.C. Code Ann. § 15-5-150. As recently reinterpreted by the Supreme Court of South Carolina in *Farmer v. Monsanto Corp.*, 579 S.E.2d 325 (S.C. 2003), § 15-

5-150 determines the capacity of a party to sue. Furthermore, *Farmer* held that "§ 15-5-150 controls the eligibility of class members in a class action where the defendant is a foreign corporation." 579 S.E.2d at 559. For suits in South Carolina state court, the effect of Farmer is to limit class membership to those persons who would have had capacity to sue for themselves.

In ruling on Ward's motion for class certification, the district court concluded that § 15-5-150 prevented Ward from representing out-of-state plaintiffs. The district court reached this conclusion by relying on our prior decisions stating that "a South Carolina federal court exercising diversity jurisdiction must apply § 15-5-150 'unless there are affirmative countervailing federal considerations.'" *Proctor & Schwartz, Inc. v. Rollins*, 634 F.2d 738, 739-40 (4th Cir. 1980) (quoting *Szantay v. Beech Aircraft Corporation*, 349 F.2d 60, 64 (4th Cir. 1965)). Our decisions in *Proctor & Schwartz* and *Szantay*, however, interpreted the door-closing statute in light of the then-prevailing understanding that § 15-5-150 restricted not capacity to sue but the subject matter jurisdiction of state courts. In Farmer the Supreme Court of South Carolina overruled its prior cases stating that § 15-5-150 dealt with jurisdiction.

In this case, we do not find it necessary to decide what effect the reinterpreted door-closing statute has on class membership in suits being heard in South Carolina federal courts sitting in diversity. This is so because, as we discuss next, Ward has failed to establish that the proposed multistate class

meets Rule 23(b)(3)'s requirement that common legal issues predominate.

B.

Fed. R. Civ. P. 23 sets the requirements for class certification. First, Rule 23(a) provides that certification is proper only if

> (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a). Once Rule 23(a)'s requirements of numerosity, commonality, typicality, and representational adequacy are met, the proposed class must still satisfy one of three additional requirements for certification under Rule 23(b). Because Ward sought class certification under Rule 23(b)(3), she was required to show that

> questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy.

Fed. R. Civ. P. 23(b)(3). The predominance requirement under Rule 23(b)(3) "is similar to but 'more stringent' than the commonality requirement

of Rule 23(a)." *Thorn v. Jefferson-Pilot Life Ins. Co.*, 445 F.3d 311, 319 (4th Cir. 2006) (quoting *Lienhart v. Dryvit Sys.*, 255 F.3d 138, 146 n. 4 (4th Cir. 2001)). The party seeking class certification bears the burden of establishing all Rule 23 requirements. *In re A.H. Robins Co.*, 880 F.2d 709, 728 (4th Cir. 1989).

In her class certification memorandum, Ward stated that "members of the Class are dispersed throughout the southern United States." S.A. 12. She further noted that "Dixie marketed and sold cancer policies in at least seven states other than South Carolina, including Alabama, Florida, Georgia, Louisiana, Mississippi, Tennessee, and Texas." *Id.* Although Ward's multistate class purported to include "at a minimum, thousands of persons" across the southern United States, Ward never identified what state law would apply to the claims of absent class members who are not residents of South Carolina and whose claims have no connection to that state. *Id.* In a class action potentially governed by the laws of multiple states, identifying the applicable body or bodies of state law is critical because "variations in state law may swamp any common issues and defeat predominance." *Castano v. American Tobacco Co.*, 84 F.3d 734, 741 (5th Cir. 1996). Ward has the burden of showing "that common questions of law predominate, and [she] cannot meet this burden when the various laws have not been identified and compared." *Gariety v. Grant Thornton, LLP*, 368 F.3d 356, 370 (4th Cir. 2004); *see also Cole v. GMC*, 484 F.3d 717, 730 (5th Cir. 2007) (decertifying a class because "[p]laintiffs have failed to adequately address, much less extensively analyze, [ ] variations

in state law") (internal quotation marks and citation omitted).

Because the district court ruled on the effect of the door-closing statute before addressing the merits of Ward's motion for class certification, it did not decide whether the proposed multistate class meets the requirements of both Rule 23(a) and Rule 23(b)(3). Even assuming that this proposed class could satisfy the requirements of Rule 23(a), Ward has not established that the multistate class satisfies Rule 23(b)(3)'s requirement that common questions of law predominate. Specifically, Ward failed to identify and compare the applicable state laws. When a plaintiff seeking certification fails to provide this analysis, it is not possible for the district court to determine whether any variations in state law "pose 'insuperable obstacles' to certification" of a multistate class. *Spence v. Glock, GES.m.b.H.*, 227 F.3d 308, 313 (D.C. Cir. 2000) (quoting *Walsh v. Ford Motor Co.*, 807 F.2d 1000, 1017 (D.C. Cir. 1986)). The need in this case to identify all governing state laws and compare any variations is underscored by the decisions in two recent cases where plaintiffs in states within the proposed geographic class made claims materially similar to Ward's. In contrast to our decision today under South Carolina law, two district courts applying contract law principles of Alabama and Louisiana concluded that the meaning of "actual charges" is unambiguous as a matter of law. *See Claybrook v. Cent. United Life Ins. Co.*, 387 F. Supp.2d 1199, 1203 (M.D. Ala. 2005); *Jarreau v. Cent. United Life Ins. Co.*, No. 05-83-FJP-SCR, 2006 U.S. Dist. LEXIS 51196 at *2 (M.D. La. May 16, 2006). In light of

Ward's failure to show that common issues of law would be predominant in a multistate class, we affirm the decision of the district court to limit class membership to South Carolina residents regardless of the effect of the door-closing statute. *See United States v. Smith*, 395 F.3d 516, 519 (4th Cir. 2005) ("We are not limited to evaluation of the grounds offered by the district court to support its decision, but may affirm on any grounds apparent from the record.").

IV.

We now turn to the cross-appeal filed by National, one of the defendants. National claims that the district court abused its discretion in certifying even a statewide class because: (1) the class is not sufficiently numerous; (2) Ward is neither a typical nor adequate class representative; and (3) individual issues will predominate the determination of class members' claims. On May 19, 2005, after the statewide class had been certified but before any party had filed a motion for summary judgment, National and Dixie petitioned this court to review the district court's certification order pursuant to Fed. R. Civ. P. 23(f). This rule grants us the discretion to entertain appeals from class certification orders prior to the entry of a final judgment. *See Lienhart*, 255 F.3d at 145. Our court applies a five-factor test to guide our discretion in deciding whether to hear such interlocutory appeals:

> (1) whether the certification ruling is likely dispositive of the litigation; (2) whether the district court's certification decision contains a substantial weakness; (3) whether the appeal will

> permit the resolution of an unsettled legal question of general importance; (4) the nature and status of the litigation before the district court (such as the presence of outstanding dispositive motions and the status of discovery); and (5) the likelihood that future events will make appellate review more or less appropriate.

Id. In their Rule 23(f) petition, the defendants raised the same objections to the class certification order that National now asserts in this appeal. We denied the interlocutory petition for review on June 23, 2005.

National's cross-appeal of the class certification is before us as a result of the appeal taken by the plaintiff, Ward, from a final judgment, namely, the summary judgment awarded to defendant National. Because we have decided to vacate that judgment and remand the case for further proceedings, National's current challenge to class certification is procedurally akin to the earlier interlocutory appeal. This circumstance leads us to conclude that it would be premature for us to address the class certification issue. Earlier, when the district court certified the statewide class, it explicitly reserved its authority to decertify or modify the class at a future date. *See McNamara v. Felderhof*, 410 F.3d 277, 281 (5th Cir. 2005) (noting that under Rule 23(c)(1)(C) the district court on remand "is free to reconsider its class certification order as often as necessary before judgment."). The defendants went on to file motions for summary judgment and for decertification of the statewide class. After the district court granted

summary judgment to National, the pending motion to decertify was denied as moot. Now, in light of the remand, the district court will be able to consider the motion to decertify. Accordingly, we dismiss without prejudice the cross-appeal filed by National. *Cf. Baskin v. Hawley*, 810 F.2d 370, 371 (2d Cir. 1987) ("Prudential considerations lead to our conclusion that these appeals should be dismissed as premature notwithstanding the fact that they are taken from what was, at that time, a 'final decision[ ]' within the meaning of 28 U.S.C. § 1291.") (alteration in original).

V.

In sum, we conclude that the meaning of the phrase "actual charges" as used in Ward's policy is patently ambiguous. We therefore vacate the district court's grant of summary judgment to National and remand with instructions for the district court to grant summary judgment to Ward on the breach of contract claims. We affirm, albeit on alternate grounds, the district court's decision to limit class membership to South Carolina residents. Finally, we dismiss without prejudice the cross-appeal filed by National challenging the district court's certification of a statewide class.

VACATED IN PART,
AFFIRMED IN PART,
DISMISSED IN PART,
AND REMANDED

UNPUBLISHED

UNITED STATES COURT OF APPEALS
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MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,

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Amici Supporting Appellees.

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Defendants.

SOUTH CAROLINA DEPARTMENT OF INSURANCE; AMERICA'S HEALTH INSURANCE PLANS, INCORPORATED,

Amici Supporting Appellant.

Appeals from the United States District Court for the District of South Carolina, at Columbia. Joseph F. Anderson, Jr., Chief District Judge. (3:03-cv-03239-JFA)

Argued: May 23, 2007 Decided: October 5, 2007

Before MICHAEL and TRAXLER, Circuit Judges, and WIDENER,** Senior Circuit Judge.

Reversed in part, affirmed in part, dismissed in part, and remanded by unpublished per curiam opinion.

PER CURIAM:

The named plaintiff in this diversity class action, Martha Ward, asserts that National Foundation Life Insurance Company (National) refuses to pay the full amount of benefits owed under supplemental cancer insurance policies that were issued by Dixie National Life Insurance Company (Dixie) and later assigned to National. At the center of the dispute is the parties' disagreement over the meaning of the policy language ("actual charges") used to determine benefits. We disagree with the district court's conclusion that, as used in Ward's policy, the phrase "actual charges" has an unambiguous meaning, and we therefore vacate the summary judgment granted to National and remand the case for further proceedings.

** Judge Widener heard oral argument in this case but died prior to the time the decision was filed. The decision is filed by a quorum of the panel. 28 U.S.C. § 46(d).

Although the district court certified a statewide (South Carolina) plaintiff class, Ward seeks to represent a multistate class. Because we conclude that Ward has failed to show that the proposed multistate class satisfies Rule 23(b)(3)'s requirement that common legal issues are predominant, we affirm the district court's decision limiting membership in the plaintiff class to those who, like Ward, are South Carolina residents. In its cross-appeal National asserts that even a statewide class is improper. In light of our remand for further proceedings, we conclude that it would be premature for us to consider the class certification issue. We therefore dismiss without prejudice National's cross-appeal.

I.

In August 1990 Ward purchased a cancer treatment benefit policy from Dixie covering both herself and her husband. Ward's policy is a type of supplemental insurance under which direct payments are made to the policyholder when an insured patient undergoes covered cancer treatments. Benefits under this kind of policy are paid regardless of whether the patient has other insurance sufficient to cover all medical expenses. When the patient has other insurance covering cancer treatments, the policyholder is able to retain the money received as a result of the supplemental coverage.

Benefits under Ward's policy vary as to the procedure performed. In some sections the policy provides clear caps as to the maximum benefit to be paid. For example, the policy provides a "Schedule of Operations" listing the maximum amount to be

paid — ranging from $150 for skin excisions to $3000 for removal of an intracardiac tumor — for a variety of operations. In many other sections of the policy no dollar amounts are provided, and benefits are calculated in relation to the "actual charges" for the covered procedures. Section (F) of the policy, titled "X-ray Therapy, Radium Therapy, Radiation Therapy, and Chemotherapy Benefit," provides an example of this language:

> We will pay the actual charges for teleradiotherapy, using either natural or artificially propagated radiation, when used for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual charges made for plaques or molds or the administration internally, interstitially, or intracavitarially of radium or radioisotopes in sealed sources for the purpose of modification or destruction of tissue invaded by cancer. We will also pay the actual charges for cancericidal chemical substances and the administration thereof for the purpose of the modification or destruction of tissue invaded by cancer.

J.A. 221. Although the phrase is used repeatedly throughout the policy, no definition for "actual charges" is provided.

Dixie assigned Ward's policy to National in 1994. In 2001 Ward began filing claims under the policy after her husband, James Ward (James), was

diagnosed with prostate cancer and started receiving treatment. Shortly thereafter, a dispute between Ward and National arose over how benefits paid in the amount of the "actual charges" are calculated.

For a number of years after the assignment, National appears to have calculated benefits in the same manner that Dixie had previously done. Specifically, when the benefit owed was based on the "actual charges," Dixie paid the benefit based on the amounts billed to patients by their medical providers. Dixie paid such amounts even though providers often have agreements with certain insurers to accept as payment-in-full an amount less than that reflected on the patient's bill. In this case, for example, James's primary health insurance is provided through a plan administered by Blue Cross and Blue Shield of South Carolina (BCBS). Regardless of the amounts billed to James, his medical providers have an agreement with BCBS that requires them to accept a discounted amount as payment-in-full for services rendered to BCBS insureds. This agreement prohibits providers from attempting to collect an amount in excess of the pre-negotiated, discounted fee from BCBS insureds such as James.

Toward the end of the year in 2001, National changed its benefit payment practice. When Ward submitted claims for James's treatments in 2002, she was told that she would have to submit an explanation of benefits (EOB) statement. By viewing the EOB, National would be able to determine what the pre-negotiated discount rate was for James's treatments and calculate benefits in light of this reduced amount. Ward refused to

provide National with the EOB statements because she contended that under the terms of her policy, the "actual charge" was reflected in the non-discounted bill that she received rather than in the EOB.

On March 7, 2003, after Ward was unable to resolve the dispute, she filed an action in the Court of Common Pleas for Richland County, South Carolina, against both Dixie and National. The defendants removed the action to federal court on October 10, 2003. On September 15, 2004, Ward moved to certify a plaintiff class consisting of

> all persons insured under cancer policies from Defendant Dixie National Life Insurance Company where Dixie promised to pay to the insured the "actual charges" incurred for certain medical services, but instead paid not the actual charges but rather the (lesser) amount that the insured's primary health insurer negotiated with the healthcare provider to pay for the medical procedure[.]

S.A. 7. On May 5, 2005, the district court certified a class of South Carolina residents. The court limited the class to South Carolina residents based on its understanding of South Carolina's door-closing statute, S.C. Code Ann. § 15-5-150. Ward, with permission of the court, filed a third amended complaint on September 27, 2005, asserting claims for (1) breach of contract against both Dixie and National; (2) bad faith refusal to pay against National; and (3) breach of contract accompanied by a fraudulent Act against National. Ward later

abandoned the bad faith claim. Cross-motions for summary judgment followed. In addition, National filed a motion, joined by Dixie, to decertify the statewide class.

On May 10, 2006, the district court granted National's motion for summary judgment while denying Ward's. The court concluded that under South Carolina contract law, the phrase "actual charges" is not ambiguous and must be read to mean "the charges for which the patient is liable when medical services are rendered, not the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. Because Ward did not prevail on her breach of contract claims, the joint motion to decertify the class and Dixie's motion for summary judgment were denied as moot.

Ward appeals both the grant of summary judgment to National as well as the district court's decision to limit class membership to South Carolina residents. National has filed a cross-appeal contesting the district court's decision to certify even a statewide class.

II.

We begin with Ward's argument that the district court erred in concluding that, as used in her policy, the unambiguous meaning of the phrase "actual charges" is the discounted amount that medical providers have agreed to accept as full payment pursuant to a third-party agreement with another insurer. Under South Carolina law when a term has a "plain, ordinary, and popular meaning," courts must interpret the term to give effect to that

ordinary usage. *Century Indem. Co. v. Golden Hills Builders, Inc.*, 561 S.E.2d 355, 358 (S.C. 2002). When a term has a plain meaning and that meaning is "clear and unambiguous, the language [of the contract] alone determines the contract's force and effect." *Schulmeyer v. State Farm Fire & Cas. Co.*, 579 S.E.2d 132, 134 (S.C. 2003). Of course not all terms are susceptible to plain and ordinary definition because of the simple fact that they are not popularly used. As a result, a contract term is ambiguous when it lacks a plain definition and is "capable of more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business." *Hansen v. United Servs. Auto. Ass'n*, 565 S.E.2d 114, 117-18 (S.C. 2002).

In the district court's endeavor to discern the plain meaning of "actual charges" as used in Ward's policy, it reasoned that the word "actual" should be given a separate meaning from the word "charges." Because the district court understood the word "actual" to mean something that is real or true, it concluded that "actual charges" means the amounts for which the patient is truly liable as opposed to "the fictional amounts indicated on the invoice that the provider does not expect the patient to pay." J.A. 1074. We disagree both with the district court's interpretive approach as well as the conclusion that it reached. The definition settled on by the district court is not the only one possible when the language of the policy is considered in light of its context. As

we explain below, the meaning of the phrase "actual charges" as used in Ward's policy is ambiguous.

First, even under the district court's approach — defining each word separately and then putting those definitions together — another meaning can reasonably be found. The words "actual charges" could also be understood to mean the amount shown on the bill sent to the patient regardless of whether this amount is the same as the amount actually owed. Viewed from within the four corners of the policy, the phrase is ambiguous as there is nothing to indicate whether "actual charges" is best understood to mean the amount actually billed or the amount actually owed. *See Conner v. Am. Pub. Life Ins. Co.*, 448 F. Supp.2d 762, 766 (N.D. Miss. 2006) (finding "inherent ambiguity in the undefined term 'actual charges'"); *Metzger v. Am. Fid. Assur. Co.*, No. CIV-05-1387-M, 2006 U.S. Dist. LEXIS 70061, at *13 (W.D. Okla. Sept. 26, 2006) (same).

Second, we disagree with the assertion that the district court was correct "in considering ordinary dictionary definitions" of both "actual" and "charges." Appellees' Br. at 21. We conclude that a person "who is cognizant of the customs, practices, usages and terminology as generally understood" in the health insurance industry would regard "actual charges" as a term of art rather than two words to be separately defined. *Hansen*, 565 S.E.2d at 117. The words are used throughout the insurance policy together as a phrase — a phrase that neither appears in a standard dictionary nor has an ordinary, popular usage. Contrary to the defendants' contention, South Carolina's principles of contract interpretation in no way prohibit courts from reading a phrase as a

term of art if that is how it would be regarded by an objective observer well-versed in medical insurance terminology. *See Frazier v. Badger*, 603 S.E.2d 587, 591 (S.C. 2004).

Third, even when viewed as a term of art, the phrase remains ambiguous. Prior to filing this lawsuit, Ward wrote to the South Carolina Department of Insurance and asked to be provided with a legal definition of "actual charge." A representative of the Department wrote back explaining that "[t]he term 'actual charge' in industry-wide standards is the amount that you are *legally obligated to pay for a specific service*." J.A. 611 (emphasis in original). In contrast to the view taken by the Department of Insurance, numerous health care dictionaries define "actual charge" as the amount billed. *See, e.g., Mosby's Medical, Nursing, and Allied Health Dictionary* 26 (4th ed. 1994) ("actual charge, the amount actually charged or billed by a medical practitioner for a service. The actual charge may not be the same as that paid for the service by an insurance plan."); Lee Hyde, *The McGraw-Hill Essential Dictionary of Health Care* 133 (1988) ("actual charge. the amount a physician or other practitioner actually *bills* a patient or his insurance for a medical *service* or *procedure*.") (emphasis in original). Because the policy itself does not indicate which definition was intended by the parties, we conclude that its meaning is ambiguous.

As the Supreme Court of South Carolina has made clear, "'Where there is ambiguity, uncertainty or doubt as to proper construction of [an insurance] contract, intention of the parties becomes a question of fact for the jury to determine.' After a

consideration of extrinsic evidence, the jury is to resolve all remaining ambiguity in favor of the insured[.]" *Waters v. S. Farm Bureau Life Ins. Co.*, 617 S.E.2d 385, 388 (S.C. 2005) (quoting *Garrett v. Pilot Life Ins. Co.*, 128 S.E.2d 171, 174 (S.C. 1962)). In light of the ambiguity of the phrase "actual charges" in the policy at issue in this case, we vacate the district court's grant of summary judgment to National and remand for further proceedings.

III.

A.

We now turn to the question of whether the district court properly limited the class of plaintiffs to those who, like Ward, are residents of South Carolina. In her motion for class certification, Ward made clear that she sought to represent persons residing throughout the southern United States who had bought policies from Dixie that were later assigned to National. Because the proposed class included non-residents of South Carolina, the district court requested briefing from the parties on the effect of South Carolina's door closing statute, S.C. Code Ann. § 15-5-150, on the potential out-of-state class members. That statute provides:

> An action against a corporation created by or under the laws of any other state government or country may be brought in the circuit court:
>
> (1) By any resident of this State for any cause of action; or
>
> (2) By a plaintiff not a resident of this State when the cause of action shall

> have arisen or the subject of the action shall be situated within this state.

S.C. Code Ann. § 15-5-150. As recently reinterpreted by the Supreme Court of South Carolina in *Farmer v. Monsanto Corp.*, 579 S.E.2d 325 (S.C. 2003), § 15-5-150 determines the capacity of a party to sue. Furthermore, *Farmer* held that "§ 15-5-150 controls the eligibility of class members in a class action where the defendant is a foreign corporation." 579 S.E.2d at 559. For suits in South Carolina state court, the effect of *Farmer* is to limit class membership to those persons who would have had capacity to sue for themselves.

In ruling on Ward's motion for class certification, the district court concluded that § 15-5-150 prevented Ward from representing out-of-state plaintiffs. The district court reached this conclusion by relying on our prior decisions stating that "a South Carolina federal court exercising diversity jurisdiction must apply § 15-5-150 'unless there are affirmative countervailing federal considerations.'" *Proctor & Schwartz, Inc. v. Rollins*, 634 F.2d 738, 739-40 (4th Cir. 1980) (quoting *Szantay v. Beech Aircraft Corporation*, 349 F.2d 60, 64 (4th Cir. 1965)). Our decisions in *Proctor & Schwartz* and *Szantay*, however, interpreted the door-closing statute in light of the then-prevailing understanding that § 15-5-150 restricted not capacity to sue but the subject matter jurisdiction of state courts. In *Farmer* the Supreme Court of South Carolina overruled its prior cases stating that § 15-5-150 dealt with jurisdiction.

In this case, we do not find it necessary to decide what effect the reinterpreted door-closing statute has on class membership in suits being heard in South Carolina federal courts sitting in diversity. This is so because, as we discuss next, Ward has failed to establish that the proposed multistate class meets Rule 23(b)(3)'s requirement that common legal issues predominate.

B.

Fed. R. Civ. P. 23 sets the requirements for class certification. First, Rule 23(a) provides that certification is proper only if

> (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a). Once Rule 23(a)'s requirements of numerosity, commonality, typicality, and representational adequacy are met, the proposed class must still satisfy one of three additional requirements for certification under Rule 23(b). Because Ward sought class certification under Rule 23(b)(3), she was required to show that

> questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is

> superior to other available methods for the fair and efficient adjudication of the controversy.

Fed. R. Civ. P. 23(b)(3). The predominance requirement under Rule 23(b)(3) "is similar to but 'more stringent' than the commonality requirement of Rule 23(a)." *Thorn v. Jefferson-Pilot Life Ins. Co.*, 445 F.3d 311, 319 (4th Cir. 2006) (quoting *Lienhart v. Dryvit Sys.*, 255 F.3d 138, 146 n. 4 (4th Cir. 2001)). The party seeking class certification bears the burden of establishing all Rule 23 requirements. *In re A.H. Robins Co.*, 880 F.2d 709, 728 (4th Cir. 1989).

In her class certification memorandum, Ward stated that "members of the Class are dispersed throughout the southern United States." S.A. 12. She further noted that "Dixie marketed and sold cancer policies in at least seven states other than South Carolina, including Alabama, Florida, Georgia, Louisiana, Mississippi, Tennessee, and Texas." *Id.* Although Ward's multistate class purported to include "at a minimum, thousands of persons" across the southern United States, Ward never identified what state law would apply to the claims of absent class members who are not residents of South Carolina and whose claims have no connection to that state. *Id.* In a class action potentially governed by the laws of multiple states, identifying the applicable body or bodies of state law is critical because "variations in state law may swamp any common issues and defeat predominance." *Castano v. American Tobacco Co.*, 84 F.3d 734, 741 (5th Cir. 1996). Ward has the burden of showing "that common questions of law predominate, and [she] cannot meet this burden

when the various laws have not been identified and compared." *Gariety v. Grant Thornton, LLP*, 368 F.3d 356, 370 (4th Cir. 2004); *see also Cole v. GMC*, 484 F.3d 717, 730 (5th Cir. 2007) (decertifying a class because "[p]laintiffs have failed to adequately address, much less extensively analyze, [ ] variations in state law") (internal quotation marks and citation omitted).

Because the district court ruled on the effect of the door-closing statute before addressing the merits of Ward's motion for class certification, it did not decide whether the proposed multistate class meets the requirements of both Rule 23(a) and Rule 23(b)(3). Even assuming that this proposed class could satisfy the requirements of Rule 23(a), Ward has not established that the multistate class satisfies Rule 23(b)(3)'s requirement that common questions of law predominate. Specifically, Ward failed to identify and compare the applicable state laws. When a plaintiff seeking certification fails to provide this analysis, it is not possible for the district court to determine whether any variations in state law "pose 'insuperable obstacles' to certification" of a multistate class. *Spence v. Glock, GES.m.b.H.*, 227 F.3d 308, 313 (D.C. Cir. 2000) (quoting *Walsh v. Ford Motor Co.*, 807 F.2d 1000, 1017 (D.C. Cir. 1986)). The need in this case to identify all governing state laws and compare any variations is underscored by the decisions in two recent cases where plaintiffs in states within the proposed geographic class made claims materially similar to Ward's. In contrast to our decision today under South Carolina law, two district courts applying contract law principles of Alabama and Louisiana

concluded that the meaning of "actual charges" is unambiguous as a matter of law. See *Claybrook v. Cent. United Life Ins. Co.*, 387 F. Supp.2d 1199, 1203 (M.D. Ala. 2005); *Jarreau v. Cent. United Life Ins. Co.*, No. 05-83-FJP-SCR, 2006 U.S. Dist. LEXIS 51196 at *2 (M.D. La. May 16, 2006). In light of Ward's failure to show that common issues of law would be predominant in a multistate class, we affirm the decision of the district court to limit class membership to South Carolina residents regardless of the effect of the door-closing statute. See *United States v. Smith*, 395 F.3d 516, 519 (4th Cir. 2005) ("We are not limited to evaluation of the grounds offered by the district court to support its decision, but may affirm on any grounds apparent from the record.").

IV.

We now turn to the cross-appeal filed by National, one of the defendants. National claims that the district court abused its discretion in certifying even a statewide class because: (1) the class is not sufficiently numerous; (2) Ward is neither a typical nor adequate class representative; and (3) individual issues will predominate the determination of class members' claims. On May 19, 2005, after the statewide class had been certified but before any party had filed a motion for summary judgment, National and Dixie petitioned this court to review the district court's certification order pursuant to Fed. R. Civ. P. 23(f). This rule grants us the discretion to entertain appeals from class certification orders prior to the entry of a final judgment. *See Lienhart*, 255 F.3d at 145. Our court

applies afive-factor test to guide our discretion in deciding whether to hear such interlocutory appeals:

> (1) whether the certification ruling is likely dispositive of the litigation; (2) whether the district court's certification decision contains a substantial weakness; (3) whether the appeal will permit the resolution of an unsettled legal question of general importance; (4) the nature and status of the litigation before the district court (such as the presence of outstanding dispositive motions and the status of discovery); and (5) the likelihood that future events will make appellate review more or less appropriate.

Id. In their Rule 23(f) petition, the defendants raised the same objections to the class certification order that National now asserts in this appeal. We denied the interlocutory petition for review on June 23, 2005.

National's cross-appeal of the class certification is before us as a result of the appeal taken by the Plaintiff, Ward, from a final judgment, namely, the summary judgment awarded to defendant National. Because we have decided to vacate that judgment and remand the case for further proceedings on the merits, National's current challenge to class certification is procedurally akin to the earlier interlocutory appeal. This circumstance leads us to conclude that it would be premature for us to address the class certification issue. Earlier, when the district court certified the statewide class, it

explicitly reserved its authority to decertify or modify the class at a future date. *See McNamara v. Felderhof*, 410 F.3d 277, 281 (5th Cir. 2005) (noting that under Rule 23(c)(1)(C) the district court on remand "is free to reconsider its class certification order as often as necessary before judgment."). The defendants went on to file motions for summary judgment and for decertification of the statewide class. After the district court granted summary judgment to National, the pending motion to decertify was denied as moot. Now, in light of the remand, the district court will be able to consider the motion to decertify. Accordingly, we dismiss without prejudice the cross-appeal filed by National. *Cf. Baskin v. Hawley*, 810 F.2d 370, 371 (2d Cir. 1987) ("Prudential considerations lead to our conclusion that these appeals should be dismissed as premature notwithstanding the fact that they are taken from what was, at that time, a 'final decision[ ]' within the meaning of 28 U.S.C. § 1291.") (alteration in original).

V.

In sum, we conclude that the meaning of the phrase "actual charges" as used in Ward's policy is ambiguous. We therefore vacate the district court's grant of summary judgment to National and remand the case for further proceedings. We affirm, albeit on alternate grounds, the district court's decision to limit class membership to South Carolina residents.

Finally, we dismiss without prejudice the cross-appeal filed by National challenging the district court's certification of a statewide class.

REVERSED IN PART,
AFFIRMED IN PART,
DISMISSED IN PART,
AND REMANDED

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

Martha Ward,	)	C/A No. 3:03-3239-JFA
	)	
Plaintiff,	)	
	)	
v.	)	
	)	
Dixie National Life	)	
Insurance Company	)	**ORDER**
and National Foundation	)	
Life Insurance Company,	)	
	)	
Defendants.	)	
	)	

This matter is before the court on the parties' cross-motions for summary judgment and a motion to decertify filed by defendant National Foundation Life Insurance Company ("National") and joined by defendant Dixie National Life Insurance Company ("Dixie"). The parties fully briefed the motions and, on April 18, 2006, the court heard extensive oral argument. For the reasons stated herein, the court grants defendant National's motion for summary judgment, thereby rendering moot the motion to decertify and defendant Dixie's motion for summary judgment. The court also denies plaintiff's motion for summary judgment.

I. BACKGROUND

On or about August 26, 1990, plaintiff Martha Ward purchased an individual cancer treatment benefit policy (the "Policy") from Dixie. Plaintiff's husband, James Ward ("James"), is listed as an insured under the Policy. The Policy is a supplemental benefits insurance policy that "provides identified benefits in the event an insured suffers a covered loss because of cancer," with benefits to be paid directly to the policyholder. The Policy states that the amount of the benefits is determined according to the "actual charges" for a particular service or treatment rendered. The term "actual charges" is neither defined in the Policy nor in any other Dixie cancer policy form. The construction of the term "actual charges" is the gravamen of the dispute.

In 1994, plaintiff was notified of the transfer of her Policy to National, and as a result, began paying her premiums to National instead of Dixie. It is undisputed that plaintiff paid all premiums due to date under the Policy. In the latter part of 2001, James was diagnosed with cancer and began receiving treatment. Plaintiff submitted claims for James's cancer treatment to National and provided the invoices from his healthcare providers as proof of loss. Initially, National adjusted and paid plaintiff the submitted claims based upon the dollar amounts stated in the providers' invoices, which amounts did not reflect the lower negotiated amounts that the provider had previously agreed to accept, and did accept, as payment in full for the services provided. Rather, in cases where a patient such as James had health insurance, the providers actually accepted as

payment in full an amount less than the amount indicated on their invoices. The providers maintain numerous agreements with various public and private health insurers in which the providers agree to accept as payment in full for their services negotiated rates lower than those indicated on their invoices. Notwithstanding the uniform charges that appear on the invoices, in reality, the negotiated rates vary from insurer to insurer.

In late 2001, National began to request the explanation of benefits forms ("EOBs") from the primary health insurer as part of its required proof of loss documentation for submitted claims. National explains that the EOBs, and not the providers' invoices, established the "loss" and the "actual charges" incurred by the insured for cancer treatment. Plaintiff refused to submit James's EOBs to National, and as a result, National refused to process the claims she submitted for his cancer treatment.

On August 14, 2002, plaintiff filed a complaint with the South Carolina Department of Insurance ("SCDOI") regarding National's request for the EOBs and the definition of "actual charges." The SCDOI responded to her on August 29, 2002, by stating in pertinent part: "Charges by providers that are discounted due to other contracts become the actual charges, as the discounted amount cannot be balanced billed to either the insurance company or the patient." The SCDOI concluded that National had handled the matter appropriately.

Plaintiff wrote a second time to the SCDOI on October 2, 2002 asking for a "legal definition" of "actual charges." On October 31, 2002, the SCDOI

responded by stating that there is "no specific definition in the South Carolina Insurance Codes and Regulations" for "actual charges." The SCDOI continued:

> Health Insurance policies are not meant to provide benefits for services for which the insured person is not legally obligated to pay. . . . Since you are not legally obligated to pay more than the State Health Plan's Allowable Charge for any specific service, National Foundation Life Insurance Company has requested copies of the State Health Plan's Explanation of Benefits (EOB's) to determine how much the provider has agreed to charge you.

The SCDOI again found that National had handled plaintiff's claims for benefits appropriately.

II. PROCEDURAL POSTURE

On March 7, 2003, plaintiff filed suit individually in state court alleging claims for breach of contract, bad faith, and breach of contract accompanied by a fraudulent act. The case was removed to this court on October 10, 2003 on the basis of diversity. Plaintiff subsequently moved to amend her complaint and sought class certification. On May 5, 2005, the court ordered class certification on the breach of contract claim, defining the "plaintiff class" as:

> All persons insured during the class period under cancer policies from

> defendant Dixie National Life Insurance Company, sold in South Carolina, where Dixie promised to pay to the insured the "actual charges" incurred for certain medical services, but where the insured was paid the amount that the insured's primary health insurer negotiated with the healthcare provider to pay for the medical procedure. The cancer policies include all cancer policies sold in the state of South Carolina regardless of the internal number assigned the policy by Dixie. Excluded from the class are the officers, directors, and employees of either of the defendants. The class period is the maximum length of time not time-barred.

Plaintiff, on behalf of herself and the class, filed a Third Amended Complaint on September 27, 2005, asserting the following claims: (1) breach of contract against both defendants; (2) bad faith refusal to pay first party claim against National;[4] and (3) breach of contract accompanied by a fraudulent act against National. In her Third Amended Complaint, plaintiff alleges that the term "actual charges" as used in her Policy and in other similar Dixie cancer policies means "benefits paid on the basis of the amount billed by the medical service provider, and

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[4] Plaintiff abandoned her bad faith claim at the hearing on April 18, 2006.

without regard to any agreements between medical service providers and third-party insurers." Plaintiff contends that National has breached the "plain language" and "unambiguous terms" of the Policy and other similar Dixie cancer policies by refusing to pay claims based upon "actual charges," as she defines it, but by instead paying based upon the "lesser amount that the insured's public or private third-party health insurer negotiated with the healthcare provider." Plaintiff is seeking compensatory damages individually and on behalf of other class members based upon the difference between the amounts stated on the providers' invoices and the amounts which National has paid as benefits under the Dixie cancer policies. Additionally, plaintiff seeks punitive damages and attorneys' fees.

III. DISCUSSION

A. SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). It is well established that summary judgment should be granted "only when it is clear that there is no dispute concerning either the facts of the controversy or the inferences to be drawn from those facts. *Pulliam Inv. Co. v. Cameo Properties*, 810 F.2d 1282, 1286 (4th Cir. 1987).

The party moving for summary judgment has the burden of showing the absence of a genuine issue of

material fact, and the court must view the evidence before it and the inferences to be drawn therefrom in the light most favorable to the nonmoving party. *United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962). When the defendant is the moving party and the plaintiff has the ultimate burden of proof on an issue, the defendant must identify the parts of the record that demonstrate the plaintiff lacks sufficient evidence. The nonmoving party, here the plaintiff, must then go beyond the pleadings and designate "specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e); *see also Celotex Corp. v. Catrett*, 477 U.S. 317 (1986).

A party "cannot create a genuine issue of material fact through mere speculation or the building of one inference upon another." *Beale v. Hardy*, 769 F.2d 213, 214 (4th Cir. 1985). Therefore, "[m]ere unsupported speculation...is not enough to defeat a summary judgment motion." *Ennis v. National Ass'n of Bus. & Educ. Radio, Inc.*, 53 F.3d 55, 62 (4th Cir. 1995).

B. PLAINTIFF'S BREACH OF CONTRACT CLAIM AGAINST NATIONAL

The material facts are not in dispute. The resolution of this case hinges on the meaning of the term "actual charges" as used in plaintiff's Policy and similar Dixie cancer policies. The construction of a clear and unambiguous insurance contract is a question of law for the court. *See S.C. Dept. of Nat. Resources v. Town of McClellanville*, 550 S.E.2d 299, 302 (S.C. 2001). Therefore, the court must first determine whether or not the Policy is ambiguous.

Plaintiff asserts that the term "actual charges" unambiguously refers to the amount a provider bills for a particular service. In her memorandum in support of her motions for summary judgment, plaintiff "concede[s] that when the evidence is construed in the light most favorable to the Defendants, the term 'actual charges' may be capable of more than one reasonable interpretation." Plaintiff relies on the various interpretations Dixie and other insurers have historically used to prove the alleged ambiguity. In addition, plaintiff points out that National itself at one time defined the term differently than it currently does, thus arguing that "actual charges" is capable of more than one reasonable interpretation. Finally, plaintiff cites to the deposition testimony of National's expert and other witnesses who define the term differently.

National argues that the court should not consider the extrinsic evidence offered by plaintiff in determining whether an ambiguity exists. Rather, National asserts that the term "actual charges" is unambiguous and should be given its plain meaning.

In construing terms of a contract, the court must first look to the language of the contract to determine the intentions of the parties. Because the court is granting summary judgment to defendant National, it must look at the evidence in the light most favorable to plaintiff. In this light, the court finds as a matter of law that the subject Policy language is unambiguous. The meaning of the term "actual charges" must be considered by reading the Policy as a whole and considering the context and

subject matter of the insurance contract.[5] Nowhere within the four corners of the Policy is the term "actual charges" used inconsistently or in a special or technical sense. Rather, the use of the term "actual charges" to mean the amounts owed to the providers as payment in full is consistent with the other language contained in the Policy. As is typical in insurance policies, the Policy only pays benefits in the event the insured suffers a "covered loss" and submits written "proof of loss." The court finds that a loss can not be construed to extend to charges for which the insured is not liable.

Furthermore, the rule of construction is that every word of a contract should be given meaning and effect if possible. See *J.A. Fay & E. Co. v. Mims*, 149 S.E. 246, 248 (S.C. 1929). The construction urged by plaintiff, that "actual charges" means whatever amount the healthcare provider puts on an invoice, would render the word "actual" meaningless, as "actual charges" would have no different meaning

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[5] The court recognizes that both defendants at one time paid claims under the Policy pursuant to the construction of "actual charges" urged by plaintiff. However, the court finds that defendants' prior actions are not to be considered in the construction of an unambiguous contract. *See Schulmeyer v. State Farm Fire & Cas. Co.*, 579 S.E.2d 132, 134 (S.C. 2003) (holding that if a contract's language is clear and unambiguous, the language alone determines the contract's force and effect); *see also, Claybrook v. Central United*, 387 F. Supp. 2d 1199 (M.D. Ala. 2005) (rejecting similar evidence and noting that subsequent conduct of the parties in observance of a contract's terms cannot be considered as aids in its construction).

from "charges." The use of the word "actual" should be given its plain and ordinary meaning in the context of the Policy. The court finds that "actual charges" are the charges for which the patient is liable when medical services are rendered, not the fictional amounts indicated on the invoice that the provider does not expect the patient to pay.

This finding is in accord with the position taken by the SCDOI. Under well-settled South Carolina law, the SCDOI's construction of the Policy is to be accorded respectful consideration and should not be overruled absent compelling reasons. *See, e.g., Dunton v. S.C. Bd. of Exam'rs in Optometry*, 353 S.E.2d 132, 133 (S.C. 1987).

Finally, at least one other federal district court has agreed with the construction urged by National and adopted by this court. In *Claybrook v. Central United*, 387 F. Supp. 2d 1199 (2005), the Alabama district court confronted a strikingly similar factual scenario,[6] with nearly the same arguments at issue. The *Claybrook* court held that the policy at issue was unambiguous and the term "actual charges" must be given its plain and ordinary meaning. The court rejected similar extrinsic evidence offered by plaintiff, holding that its analysis was confined to the "four corners of an instrument unless the

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[6] The Plaintiff initially attempted to certify a nationwide class in this case to include all of the Central United cancer policies, including the Alabama policies at issue in *Claybrook*, on grounds that the terms and benefits in the Central United policies are sufficiently similar, if not identical, to the Dixie cancer policies assumed by National in South Carolina.

instrument contains latent ambiguities." *Id.* at 1203. The *Claybrook* court found that "in everyday and plain language, the term 'actual' means 'real,' 'existing,' not 'potential' or 'possible.'" *Id.* at 1204. The undersigned finds the Claybrook court's analysis well-reasoned and persuasive.

The court, having found that National properly construes the term "actual charges" to mean the amount accepted by the healthcare provider as payment in full, finds that plaintiff's claim for breach of contract must necessarily fail. Plaintiff alleges that "Defendants breached the contract by refusing to pay Plaintiff and other class members 100% of the 'actual charges', and instead proposing to pay claims based on the reduced 'negotiated fees'." The court finds that a patient's EOB provides the necessary proof of loss for payment of benefits, because the EOB, and not the provider's invoice, shows the true cost of the service rendered and the real price paid for such service. Because National has not refused to pay the benefits owed pursuant to the terms of the Policy, as a matter of law, it cannot be found liable to plaintiff for breach of contract. Upon receipt of the requisite proof of loss from plaintiff, National has indicated its willingness to provide the benefits owed. Therefore, plaintiff cannot recover on her breach of contract claim against National, and the court grants National's motion for summary judgment.

C. PLAINTIFF'S BREACH OF CONTRACT CLAIM AGAINST DIXIE

The court finds that this order renders moot any remaining issues in Dixie's Motion for Summary Judgment. Plaintiff argues that any damages

suffered by plaintiff and the class were caused by contractual breaches by Dixie's assignee, National. Thus, plaintiff asserts that Dixie, as assignor, is liable for any wrong committed by National. As National is absolved of liability, plaintiff's breach of contract claim against Dixie is likewise dismissed. Therefore, the court need not reach the issues raised by Dixie in its motion for summary judgment.

D. PLAINTIFF'S BREACH OF CONTRACT ACCOMPANIED BY A FRAUDULENT ACT CLAIM

Because breach of contract is an essential element to plaintiff's second claim for breach of contract accompanied by a fraudulent act, the court grants summary judgment for National on plaintiff's claim.

IV. CONCLUSION

For the foregoing reasons, the court grants defendant National's motion for summary judgment [#216], and denies plaintiff's motion for summary judgment [#212]. This decision renders moot the motion to decertify [#219] and defendant Dixie's motion for summary judgment [#215].

IT IS SO ORDERED.

May 10, 2006 — s/ Joseph F. Anderson, Jr.

Columbia, South Carolina — United States District Judge

March 16, 1999

J. Earl Deaton
969 Amick's Ferry Road
Chapin, SC 29036

In Reply Refer To: 1999057-083-004
National Foundation Life Insurance Company

Dear Mr. Deaton:

We are enclosing a copy of the response received from the above-captioned company, by this Department, on March 15, 1999, to the complaint you filed with this office. We regret our response to you could not be more favorable, but based on the documentation received, it appears this matter has been handled appropriately by the company. Mr. Deaton, when a provider renders medical services to a Medicare eligible patient and accepts Medicare's assignment, they accept as their actual charge Medicare's approved allowable amount. That provider may not bill you more than the approved amount when they accept Medicare assignment. Therefore, the company needs the Medicare Explanation of Benefits to determine the "actual charges" so that the claim may be processed.

We are closing our file since we have no further jurisdiction in this matter. Thank you for the opportunity to serve you

Respectfully,

MARY ANN O'BRIEN
Insurance Regulatory Analyst
Consumer Service Division

Enclosure
cc: James Byrd
Deputy Director
Consumer Services Division

Division of Administration
Office of Consumer Services
300 Arbor Lake Drive, Suite 1200
Columbia, South Carolina 29223

Mailing Address:
P.O. Box 100105, Columbia, S.C. 29202-3105
Telephone: (803) 737-6180 or 1-800-768-3467

April 18, 2002

Mr. James Hawkins
The Methodist Oaks
Box 9005
Orangeburg, South Carolina 29116

In Reply Refer To: 112511
National Foundation Life Insurance Company

Dear Mr. Hawkins:

We are enclosing a copy of the response received from the above-captioned company, by this Department on April 18, 2002, relative to the complaint you filed with this office.

Mr. Hawkins, your insurer is requesting copies of the Medicare Explanation of Benefits to determine the allowable amount covered by Medicare. An insured or an insurer is not liable for charges, which an individual is not legally responsible for. Since you [sic] physician accepted Medicare assignment, you are not legally liable for anything over the allowable amount and therefore the insurer is not responsible for any amount over the allowable amount. This, Mr. Hawkins is standard industry practice. This company is not doing anything any

different did [sic] other carriers in the same type situation [sic].

Therefore, you must provide the Explanation of Benefits needed by the insurer for continued processing of your outstanding claims.

We trust this the [sic] information is helpful in understanding the actions of the company. We are closing our file, since we have no further jurisdiction in this matter.

Respectfully,

ALICIA CORNELIUS
Insurance Regulatory Analyst
Consumer Service Division

Enclosure

NFL NATIONAL FOUNDATION LIFE
INSURANCE COMPANY

August 9, 2002

Ms. Martha Ward
1912 Amick Drive
Gilbert, SC 29054

Re: Claimant: James A. Ward
Policy Number: 02KC598860
Claim Numbers: 021910119 and 021900142

Dear Mrs. Ward:

This is in response to your July 22, 2002, inquiry regarding the above referenced Policy. Our records indicate that you purchased a Cancer Treatment Benefit Policy that was issued with an effective date of August 26, 1990. The Policy provides benefits according to a schedule of benefits, for loss resulting from hospital confinement, or other specified expenses incurred for the treatment of Cancer. The availability of benefits is subject to the definitions, benefit provisions, exceptions and limitations. As you are aware, the majority of the benefit categories in your Policy are limited in their benefit structure to the amounts specified; however, some are not, as in the case of the "X-ray, Radium Therapy, Radiation Therapy and Chemotherapy Benefit". This benefit would be considered unlimited based on actual charges for such services. Since the Policy provides benefits on an actual charge basis, the Explanation of Benefits statements from Blue Cross/Blue Shield are required to take into consideration any discounted or written-off amounts that may have been applied to the charges that were originally

NFL NATIONAL FOUNDATION LIFE
INSURANCE COMPANY

billed. Since any amounts written-off by a provider cannot be balance billed to insurance companies or the patient, such amounts cannot be considered as actual charges. Your Policy also states that we will "...pay benefits to which you are entitled immediately upon receipt of the proof of loss supporting the claim." As the Explanation of Benefits statements from Blue Cross/Blue Shield are needed to verify your actual loss, they must be submitted in order to establish proof of loss for your claim. At this time, the above referenced claims are pending Blue Cross/Blue Shield Explanation of Benefits statements. Once these statements have been received, we will be able to continue with processing of Mr. Ward's claims. I [sic] you have any questions, please feel free to contact me directly at 1-800-221-9039, extension 455.

Sincerely,

Joan Turner
Assistant Vice President
Communications Department

ksf/JT

Martha J. Ward
1912 Amick Drive
Gilbert, SC 29054
August 14, 2002

SC Department of Insurance
Ernst N. Csiszar, Director
P.O. Box. 100105
Columbia, SC 29202

Dear Mr. Csiszar:

Please find enclosed a copy of a cancer policy that I purchased July 26, 1990 through Dixie National Life Insurance Company, which was later sold to National Foundation Life Insurance Company. The policy covers both my husband and myself. I have had the unfortunate need to make claim against this policy beginning in January of this year for my husband.

I received the indicated payment amount for the initial diagnosis by providing a pathology report. I then submitted two subsequent claims for radiation treatment attaching a UB52, which I was told was the industry standard for paying actual charges on a cancer policy. I received a request to provide EOB's for those dates of service and I explained that my policy stated "actual charges" were to be reimbursed, and that documentation had been provided along with the claim. I received payment for those two claims.

My questions are as follows:

- At the time my policy was issued, what were insurance companies required to pay when the

term "actual charges" was used to denote the amount of reimbursement?

- What type of documentation was to be provided to establish the "actual charge" of my covered procedure?

- If the definition of "actual charges" has changed since the issuance of my policy, I would like to know the date of the change and, if and how this change was to be conveyed to any affected policyholders. I have kept all of my correspondence associated with this policy and I don't have any document that indicates a change in any portion of my policy.

My intention is not to defraud anyone. My understanding of actual charges was the amount a doctor or facility charges for a procedure, not withstanding any agreements those doctors or facilities may have with my insurance provider, which my [sic] affect the amount I would owe to the doctor or facility.

I await your response.

Sincerely,

Martha J. Ward
(803) 896-6830 work
(803) 892-6545 home

SOUTH CAROLINA
DEPARTMENT OF INSURANCE

300 Arbor Lake Drive, Suite 1200
Columbus, SC 29223

P.O. Box 100105
Columbia, South Carolina 29202-3105
(803) 737-6180 or 1-800-768-3467

August 29, 2002

Ms. Martha J. Ward
1912 Amick Drive
Gilbert, SC 29054

In Reply Refer To: SC114610
National Foundation Life Insurance Company

Dear Ms. Ward:

We are enclosing a copy of the response received from the national Foundation Life Insurance Company, by this Department on August 29, 2002 to the complaint you filed with this office. We regret our response to you could not be more favorable, but based on the documentation received, it appears the company has handled this matter appropriately.

Charges by providers that are discounted due to other contracts become the actual charges, as the discounted amount cannot be balanced billed to either the insurance company or the patient.

We are closing our file since we have no further jurisdiction in this matter. Thank you for the opportunity to serve you.

Respectfully,

Bill Lemmon
Insurance Regulatory Analyst
Consumer Services Division

Enclosure

Ms. Martha J. Ward
1912 Amick Drive
Gilbert, SC 29054
October 2, 2002

SC Department of Insurance
Ernst N. Csiszar, Director
P.O. Box 100105
Columbia, SC 29202

Dear Mr. Ciszar:

This is in response to a recent correspondence by Bill Lemmon of your office. In my letter to you dated August 14, 2002, I specifically asked the SC Department of Insurance's bearing on an insurance company's obligation to pay claims when the term "actual charges" was used to denote the amount of reimbursement. My second question was, if the definition of "actual charges" has changed since the issuance of my policy, July 1990.

I do not feel that Mr. Lemmon handled my inquiry in my best interest. What I received from him was the enclosed letter dated August 29, 2002 with a response from the National Foundation Life Insurance Company dated August 27, 2002. I was already aware of National Foundation's position of my request. I am interest in the definitions of SC Department of Insurance.

I had two insurance agents who are licensed to write cancer policies in the state of South Carolina to review my policy. They both stated that they have written policies with the term "actual charges" prior

to 1992 and those policies have no bearing on a patient's benefits with any other policy they may carry. As you are aware, my policy was written, July 1990, when the State Health Insurance offered by Blue Cross-Blue Shield of SC did not have pre-negotiated reimbursement rates with physicians and/or health care providers, therefore payment was made according to the charges submitted. If National Foundation Life Insurance Company is allowed to make reimbursement changes without filing amendments to policies with the SC Department of Insurance, what keeps all other companies who wrote policies prior to 1992 the same luxury? [sic]

I would very much like to finalize this issue, therefore I am asking for an audit by your office on the reimbursement laws of cancer policies written prior to 1992 when the state health insurance company developed pre-negotiated rates with health care providers.

I await your response.

Sincerely,

Martha J. Ward
(803) 896-6830 work
(803) 892-6545 home

SOUTH CAROLINA
DEPARTMENT OF INSURANCE

300 Arbor Lake Drive, Suite 1200
Columbus, SC 29223

P.O. Box 100105
Columbia, South Carolina 29202-3105
(803) 737-6180 or 1-800-768-3467

October 31, 2002

Ms. Martha J. Ward
1912 Amick Drive
Gilbert, SC 29054

In Reply Refer To: 114810
National Foundation Life Insurance Company

Dear Ms. Ward:

You have asked that our Department provide you with a legal definition of "actual charge." There is no specific definition in the South Carolina Insurance Codes and Regulations. The term "actual charge" in industry-wide standards is the amount that you are *legally obligated to pay for a specific service.*

Under South Carolina Insurance Regulation 69-34 G (8) it is indicated that a Specified Disease and Specified Accident Insurance Coverage policy can provide benefits in one of two ways, on an expense-incurred basis or an indemnity basis.

Your Cancer Policy, purchased from Dixie National Life Insurance Company is a specified disease policy providing benefits on an expense-incurred basis.